Managed Risk Medical Insurance Board
March 24, 2004, Meeting

Board Members Present:	Cliff Allenby, Areta Crowell, Ph.D., Richard Figueroa, Virginia Gotlieb, M.P.H.
Ex Officio Members Present:	Jack Campana, David Topp
Staff Present:	Lesley Cummings, Joyce Iseri, Laura Rosenthal, Lorraine Brown, Irma Michel, Tom Williams, Vallita Lewis, Janette Lopez, Larry Lucero, Crystal Milberger, Teresa Smanio, JoAnne French, Mercedes Kneeland

REVIEW AND APPROVAL OF MINUTES OF MARCH 3, 2004, MEETING

The following correction was made to the first sentence of the second paragraph on page two:

"Dr. Hernández indicated that she thought ~~the LAO advice to triage~~ triaging children on the basis of ~~waiting list by income and/or~~ medical need ~~had merit~~ was appropriate."

It was noted that the draft mailed with the agenda had already been corrected on page four by adding a fifth motion under the health, dental, and vision plan extensions and amendments.

A motion was made and unanimously passed to approve the minutes of the March 3, 2004, meeting as corrected.

STATE BUDGET UPDATE

Tom Williams reported on the March 8 Senate subcommittee budget hearings that affect MRMIB programs as follows:

1. Deleted funding for the 2005 consumer satisfaction survey, saving $175,000 from the general fund and $500,000 in federal funds.

2. Rejected the proposed cap on enrollment, while indicating that the subcommittee would work on other cost-containment strategies.

3. Rejected the Administration's proposal to block grant to counties several programs for legal immigrants, including HFP services.

4. Without prejudice, rejected trailer bill language that would establish a two-tiered benefit structure, and instead directed the Administration to make the proposal in a policy bill.

5. Adopted the Legislative Analyst Office's recommendation to eliminate the AIM reserve fund of approximately $1 million and return the funds to the Prop 99 reserve.

Chairman Allenby asked if there were any questions or comments; there were none.

LEGISLATIVE UPDATE

State Bill Summary

Teresa Smanio reviewed some of the bills being followed by MRMIB that have been introduced or changed since the last state bill report. AB 2985 (McCarthy) would suspend SB 2 (Burton & Speier) requirements for at least two years whenever EDD determines California's unemployed rate is 7% or more. This bill would only become operational if SB 2 is not repealed at the election in November.

SB 2: California Health Care Foundation is providing funding for the development of issue papers on implementation of SB 2. The request for proposal (RFP) has been released and is attached to the bill summary handout. Responses are due April 16; work on the issue papers will begin in May.

SB 1631 (Figueroa) is similar to AB 32 (Richman), and would establish the Cal-Health Program to coordinate Medi-Cal and HFP in order to reduce administrative costs. DHS and MRMIB would carry out the duties of the program. Ms. Smanio reviewed some of the details of how the program would operate. DHS and MRMIB would provide the Legislature with recommendations for making Medi-Cal and HFP operate as similarly as possible to the extent permitted by federal law. SB 1631 would require schools and health care providers to aid in outreach and enrollment. This bill was drafted in response to SB 480 (Solis) which required the Health and Human Services Agency (HHSA) to examine options for providing universal health care coverage.

Chairman Allenby asked if there were any questions or comments; there were none.

SB 1196 (Cedillo)

Teresa Smanio reviewed the staff's analysis of SB 1196 (Cedillo). Building on existing law for express enrollment in Medi-Cal through the National School Lunch Program (NSLP), this bill requires counties to forward NSLP applications to HFP if the student is determined to be ineligible for Medi-Cal with the parents consent. Ms. Smanio detailed some of the provisions of the law. MRMIB staff recommends supporting SB 1195 with suggested amendments to address technical concerns. Chairman Allenby asked if there were any questions or comments; there were none.

EXECUTIVE ORDER S-02-03: REGULATION REVIEW

Laura Rosenthal reported that during the transition of the new Administration, Governor Schwarzenegger issued an order requiring departments to assess the business impact of any proposed regulations, and to re-analyze the business impact of regulations adopted since January 6, 1999. These analyses were to be independent from any analyses done previously by the department or the Office of Administrative Law. Staff concluded that all previously adopted regulations and MRMIB's one pending regulation (AB 1401 (Thomson)) meet applicable standards. A copy of staff's analyses pursuant to EO S-0203 was provided to the Board.

Richard Figueroa asked what response was anticipated from the Administration. Ms. Rosenthal replied that her understanding from HHSA chief counsel is that the MRMIB's review of the pertinent regulations will be reviewed by the Governor's legal affairs office and forwarded to the cabinet secretary, with no response expected.

MEDI-CAL RESTRUCTURING

David Topp, ex officio member of the Board and MRMIB's representative at HHSA, reported on HHSA's efforts to-date to redesign the Medi-Cal program. Medi-Cal has become a very significant cost to the state, having grown 41% since 1988/89. California can be proud of the program's expansion and increased accessibility to citizens. While looking at ways to the save costs, both the Governor and Secretary Belshé determined that the coverage expansions were laudable and they will work hard to maintain Medi-Cal's level of services, especially to children. However, the program needs to become more effective.

Thus, the Administration has called for a redesign of the program. It's objectives are to continue services to children, encourage personal responsibility, promote work participation, and improve effectiveness and accountability. MRMIB staff has been involved. Meetings have been held statewide. The principals are looking at the way other states, such as Oregon and Utah, have restructured their Medicaid programs, and have met with Secretary Thompson of the federal HHSA. DHS has discussed with the Centers for Medicare and Medicaid Services (CMS) a large, comprehensive 1115 waiver that would present the state with significant flexibility.

Mr. Topp discussed some other ideas for the redesign, for instance, simplifying the eligibility process, including determination of family financial responsibility, and modifying the benefit structure for optional eligibles, including the addition of tiered benefits, modifying the delivery system by placing more beneficiaries in managed care and organized systems of care.

Mr. Topp noted that the timetable for the redesign is quite aggressive. Because the Administration wants stakeholder input in designing the waiver, five stakeholder work groups were formed in January and February. He noted that some have said that DHS

already has a proposal and does not really want input. He said this is untrue--there is no pre-prepared proposal. He emphasized it is a work-in-process. He described the various responsibilities of the five groups. The California Health Care Foundation (CHCF) is also providing valuable resources, having funded a facilitator and maintaining a special web site. Interested parties can track the progress and make comments on HHSA's web site at www.mcreform@dhs.ca.gov and CHCF's web site at www.medi-calredesign.org. CHCF's web site also has audio web casts of meetings.

Dr Crowell said she appreciated the Administration's openness. People should be delighted with ideas for streamlining the application process as there are problems with the current application process. She cautioned that services for adolescent care and mental health are not well done in the private model (such as HFP). She also stated that it was important to retain the EPSDT program.

Chairman Allenby asked for more detail on the timeline. Mr. Topp replied that work groups will continuing working through the end of April, consultants will submit reports in early May, and a concept paper will be submitted to the Legislature in May. The Legislature would adopt any needed trailer bill language at that time. The state would then submit a waiver application to CMS probably in October, with the view of obtaining an expedited review. Hopefully approval would be obtained in December and implementation would phase in from January to July, with actual implementation targeted for July 1, 2005. Chairman Allenby agreed this is an ambitious timeline.

Chairman Allenby asked if there were any questions or further comment; there were none.

AIM/HFP EMERGENCY REGULATIONS

Chairman Allenby announced the AIM/HFP regulations were before the Board as an action item to rescind the emergency regulations adopted for filing with the Office of Administrative Law (OAL) at the January 28 meeting.

Joyce Iseri explained that the purpose of the regulations is to transition AIM infants into HFP. Stakeholders and the health plans brought up concerns about ensuring health services to infants not yet enrolled in HFP. Changes were made to the regulations to provide for an enhancement addressing their concerns. Ms. Iseri went through the regulatory changes proposed. The enhancements make it easier for a mother to enroll her newborn in HFP and, in effect, will overlook the first two or three months of premiums if the mother does not enroll her infant at the time of its birth. Ms. Iseri provided an illustration of how the process would work as a result of these changes.

Ms. Rosenthal emphasized that the proposal waives premiums as a pre-condition for enrollment, but the obligation to pay is not waived. Rather than making enrollment conditional upon payment of premiums, the premiums could be paid retroactively to the first month they are due, allowing the infant to receive services the first time it is

presented to an HFP provider even if the administrative vendor (AV) has not been notified and paid the premiums.

Lucy Quacinella, from Maternal & Child Health Access, thanked staff for making this change. The new language, which she was seeing for the first time, addressed much of their concern. They would like assurance that families will not be billed directly by the physician or hospital for services rendered the infant before it is technically enrolled in the program. She said it was not clear to her that the HFP regulations interfaced with the AIM regulations to ensure that they clearly reflect what has been explained as the intended changes. She asked if they could continue to work with staff on the language. Chairman Allenby replied that they could. Ms. Iseri said staff would be happy to continue to work with her on the regulations, with the understanding that the regulations need to be filed with the OAL.

Ms. Quacinella also asked if they could review the draft of the notices the AV will provide subscribers in order to have an opportunity to comment and better assist the families they represent. Chairman Allenby asked if there were any further comments or questions; there were none.

Ms. Iseri pointed out to the Board the need to make a minor technical correction to the draft regulations before the Board (page 22 for HFP and page 2 for AIM). A motion was made and unanimously passed to rescind the AIM/HFP emergency regulations adopted for filing with the Office of Administrative Law at the Board's January 28, 2004, meeting, and to adopt the AIM/HFP emergency regulations presented to the Board today for filing with the OAL.

HEALTHY FAMILIES PROGRAM (HFP) UPDATE

Enrollment and Single Point of Entry (SPE) Reports

Irma Michel noted that today's report was the first since MAXIMUS had taken over as administrative vendor on January 1.

She reported that there were 694,480 children enrolled in HFP as of March 28, 2004, of whom 13,216 enrolled in January. She reviewed the enrollment data that included the ethnicity and gender of subscribers, the top five counties in enrollment, SPE statistics, and the breakdown of applications processed with and without assistance.

Ms. Michel explained that the low enrollment in January was due to some system problems, backlogs, and the fact that MAXIMUS didn't begin processing enrollment until January 5. She pointed out that there has been an increase in the percentage of applications going to Medi-Cal, presumably because of the CHDP Gateway program. The number of applications being processed without assistance increased to 80%, resulting in more incomplete applications. Ms. Gotlieb asked if the percentage of incomplete applications remained high. Ms Michel replied that about 75% of applications were incomplete since November and the program was still seeing that

percentage. Also, now staff is seeing very incomplete applications. These are applications that have data missing and a Medi-Cal screening can not be done. Staff has to spend time calling the families at SPE to get the information in order to continue the process. The AV should be caught up with February and March data by mid-April. By the end of March, the full enrollment report for January will be available on the web site at www.mrmib.ca.gov.

Administrative Vendor (AV) Implementation Status

Ms. Michel provided a follow-up on transition problems that were reported by advocates and CAAs. She noted that staff has devoted considerable time working closely with advocates and CAAs on the different issues. In the process, staff learned of several problems.

1. A decision had been made not to convert all denial and disenrollment data done by EDS and to convert active cases in January. Those people who received denial/disenrollment letters which had been sent out by EDS who were when contacted MAXIMUS could not be assisted since they were not in the system. This problem was fixed in early February.

2. Staff discovered that some HFP mail had, for some reason, been sent to a post office box unknown to MRMIB. The box contained payments, applications, and requests for information. This box was designated for requests for information as a result of flyers at schools; it was not intended to receive applications and payments. Staff is working with the post office to find out who owns the box so MRMIB can take it over.

3. There is an increase in the number of applications arriving through the SPE that are very incomplete, e.g., without names, birth dates, or income information. These applications, which Ms. Michel referred to as "very incomplete," are missing information needed to screen to Medi-Cal and HFP. These applications were not forwarded to the programs and were "stuck" in SPE. Calls are being made in order to complete the applications. This system glitch has been fixed and a process has been set up to work these type of applications.

   Ms. Cummings added this is a new problem never experienced before, and is not a result of the transition. Ms. Gotlieb asked if they were coming from a particular place. Ms. Michel said staff could not tell. She stated that she has been meeting with the Covering Kids Coalition in an effort to have more people assist families with their applications. Ms. Cummings noted that this "very incomplete" application problem is happening at the same time as the implementation of the CHDP Gateway.

4. The system was not processing AER disenrollments correctly in January and February. The system "closed" the cases—but did not notify plans or subscribers of disenrollments. Because the subscribers had not had notice of disenrollment,

they could not be disenrolled, so staff had to continue their enrollment until March 31. Subscribers have since been notified. Some of these subscribers will be able to demonstrate their continued eligibility, but those who do not will be disenrolled in March. Thus, disenrollments will appear higher in March as a result.

Ms. Michel introduced Kari Dingman, Vice President from MAXIMUS, to discuss how MAXIMUS had or would remedy the problems. Regarding the AER disenrollment problem, MAXIMUS began producing reports beginning March 2 identifying who was affected by the system's failure to notify subscribers about disenrollment. Once a subscriber is identified, their eligibility is extended through the end of the month and he or she is sent a notice. Mr. Topp asked how many subscribers were involved. Ms. Michel replied approximately 29,000. He asked what the cost implications were of this problem. Ms. Cummings replied approximately $1.5 million general funds. Mr. Topp asked how the cost would be covered. Ms. Cummings replied that HFP expenditures were below budget due to lower than expected enrollment. Mr. Figueroa noted that those were subscribers who would be found ineligible due to income being too low or too high, or failure to provide income documentation. Mr. Topp said that the question is, how big is that slice. Ms. Michel stated that those that had income too low would not be disenrolled. They were placed on a two-month bridge and forwarded to Medi-Cal. Some cases would be reinstated through appeals or information received on time.

Mr. Campana asked if all the affected subscribers have received a phone call. Ms. Dingman replied that they have, in addition to a letter. Mr. Figueroa asked if a person would have continued to receive services after they were no longer eligible at AER. Ms. Michel replied that they could have received services.

Chairman Allenby commented that every new system has glitches. It is something that inevitably happens. He then called for public comment.

Lucy Quacinella (MCHA) emphasized that there is no application assistance because the state cut funding for this service. The increase in incomplete applications slows down the processing of applications for people who are eligible, thus delaying their access to the program. It is a problem of administrative inefficiency that needs to be addressed.

Chairman Allenby asked if there were any further questions or comments; there were none.

Advisory Panel Vacancy

A motion was made and unanimously passed to appoint Barbara Clifton Zarate to fill the vacant subscriber position on the HFP Advisory Panel.

CHDP Gateway Data

Ms. Michel reported on enrollment that HFP had received as a result of the CHDP Gateway program. CHDP Gateway started in July 2003. By January 2004, DHS had sent out over 200,000 applications in response to requests from families whose children had been designated as presumptively eligible for HFP or Medi-Cal. Few of these applications end up being filled out and submitted to the SPE (2,981 in January 2004, 11, 410 from July to October 200). Of those applications that are submitted to SPE, the majority (around 60%) are referred to Medi-Cal. Of the applications that are referred to HFP, a very high percentage (74% during July through October 2003, 66% in January 2004) are denied. The biggest single reason for denial is that the applications are missing documentation. Enrollment in HFP was 638 in January 2004 and 1,105 from July to October 2003. Staff will know more when they see the February and March reports.

Chairman Allenby asked if incomplete applications can be attributed to a lack of assistance. Ms. Michel replied that lack of assistance makes a big difference. Mr. Figueroa asked if Medi-Cal has a similar percentage of incomplete applications. Ms. Michel replied that staff only has information for HFP. Ms. Gotlieb emphasized that this highlights the problem of not having enrollment assistance. Dr. Crowell asked what the timeframe is for calling subscribers to obtain missing information. Ms. Michel replied they are called within three days of leaving the SPE. The new AV has increased the number of calls from three to five. Dr. Crowell asked what information seemed to be missing the most. Ms. Michel replied that it was income. Dr. Crowell indicated a system with a scanner could send the information electronically right away. Such a system is used in Santa Cruz today.

Chairman Allenby called for public comment.

Lucy Quacinella commented that they are strongly in favor of application assistance plus a simple one-time, electronic application for CHDP, as opposed to the need for a second application, to address these problems. Just one of these suggestions would improve enrollment. Ms. Rosenthal noted that this would require legislation. Chairman Allenby said it could be done with trailer bill language.

AB 495 (Diaz) Update

Janette Lopez reported the original state plan amendment (SPA) was submitted to CMS in March 2003. This SPA would allow counties/local initiatives to put up matching funds for federal funds to provide coverage for children with family incomes between 250-300% FPL.

In addition, the SPA included changes associated with two other purposes: consolidating all prior SPAs (12) into one document and obtaining federal funding for children born to AIM mothers, specifically, for first-year infants in families with incomes

250-300% of FPL, and for the children's second year coverage for those born to mothers enrolled in AIM on or before July 1, 2004.

CMS sent a "stop the clock" letter on May 15, 2003, with various questions focusing mainly on the consolidation. On June 12, CMS sent a subsequent letter raising issues regarding local initiatives and the source of funds for the non-federal share. In a subsequent meeting, CMS made it clear that getting approval for local initiatives as a public entity would be a challenge. Staff spent many months working with the four counties included in the SPA (Alameda, San Francisco, San Mateo, and Santa Clara) to revise it to reflect that the counties, versus local initiatives and County Organized Health Systems, would provide the match. The source of funding was also revised to indicate county revenues and tobacco settlement dollars would be used instead of health plan reserves. On March 9, 2003, MRMIB resubmitted the SPA.

The day before the Board meeting Ms. Cummings, Ms. Iseri, and Ms. Lopez participated in a one and one-half hour conference call with CMS where some new questions were raised requiring simple changes to the SPA. Just prior to the Board meeting, CMS requested the SPA be considered a draft, rather than a final submission, which would allow CMS to preserve their review dates. Some of the issues CMS brought up staff thought they had already resolved. Chairman Allenby directed staff to vigorously pursue the SPA. He asked if there were any questions or comments; there were none.

2003 Federal Annual Report

Vallita Lewis presented the 2003 Federal Annual Report. In order to comply with Title XXI, MRMIB is required to provide the federal government with an annual report on SCHIP. The time period of this report is October 1, 2002, through September 30, 2003 (the federal fiscal year).

Ms. Lewis went through the report, highlighting notable information regarding program changes, performance goals, enrollment, financing, challenges, and accomplishments such as the progress made in reducing the number of uninsured, low income children. The report will be available on the web site at www.mrmib.ca.gov. Chairman Allenby indicated the Board was pleased with the report. Ms. Gotlieb remarked it appears staff works 24 hours a day. Dr. Crowell remarked that the report contains the answer to any question posed about the program.

Consumer Satisfaction Survey - Health Plan

Crystal Milberger went through the 2004 Consumer Survey of Health Plans, highlighting notable information and explaining some of the information contained in charts. The survey consisted of 76 questions and was conducted in English, Spanish, Cantonese, Korean, and Vietnamese. 21,715 families were surveyed. The report can be viewed on the web site at www.mrmib.ca.gov.

Mr. Campana asked about missing data (NM) in tables 2 and 3. Ms. Milberger explained that plans with NM had submitted the data. However, because the results were based on an insufficient number of children, conclusions about the plans' performance is not appropriate. Ms. Gotlieb asked if the those surveyed were confused about who "specialists" were. Ms. Brown replied that various organizations participated in the development of the tool and it had been subjected to considerable review and testing (to ensure that the answers received from survey participants are consistent with what is expected). Responses in this area have been low compared to other responses since the survey began. Dr. Crowell found the analysis to be very helpful and suggested the plans make use of the information. Ms. Cummings pointed out that the Senate budget subcommittee has proposed cutting funding for this survey in the budget year. Chairman Allenby asked if this came from the subcommittee directly or if it was recommended by the LAO. Ms. Cummings replied that it came directly from the subcommittee whose staff has talked about cutting the survey in the past.

Consumer Satisfaction Survey - Dental Plan

Ms. Milberger went through the 2004 Consumer Survey of Dental Plans. Since California is the only state that administers the dental survey, this report does not include a comparison with other state programs. The survey contained 70 questions posed to 4,500 families. Ms. Milberger explained that since the dental survey is still being developed, a protocol for telephone follow-up was not available. She pointed out notable information throughout the report. This report can also be viewed on the web site at www.mrmib.ca.gov.

ACCESS FOR INFANTS AND MOTHERS (AIM) UPDATE

Enrollment Report

Larry Lucero reported that there are currently 4,458 mothers and 11,883 infants enrolled in the program. He briefly reviewed the enrollment data, including ethnicity, infant gender percentage, and the counties with the highest percentage of enrollment. Chairman Allenby asked if there were any questions or public comment; there were none.

Administrative Vendor (AV) Transition Plan

Ms. Michel reviewed the transition plan for the administrative AV for AIM. She reported that staff met with Care 1st to begin the process of transferring AV services to MAXIMUS. This transition will be much easier and faster than the HFP transition. It will be completed by July 1 and provide more services for AIM mothers.

MAJOR RISK MEDICAL ISURANCE PROGRAM (MRMIP) UPDATE

Enrollment Report

Mr. Lucero reported that there are 7,815 people currently enrolled in the program, of whom 3,725 were enrolled in 2003-04. As of March 3, there are 71 on the waiting list serving the post-enrollment waiting period. During the month, 151 people were disenrolled pursuant to AB 1401, bringing the total number of 36-month disenrollments to 9,746. The program remains open to new subscribers since current enrollment is below the cap of 11,187.

Mr. Figueroa asked if the Legislature has done any follow up on AB 1401, e.g., how long people are staying in guaranteed coverage. Ms. Cummings replied that they have not, but there have been a number of complaints. The statute requires the Legislative Analyst's Office to do an evaluation. Staff has already met with them. Staff was also contacted by the National Conference of State Legislators staff on AB 1401.
Mr. Figueroa asked if plans had submitted any information on costs. Ms. Cummings replied that MRMIB was making interim payments based on a formula at this time. Actual cost data will not come in for a year.

Chairman Allenby recessed the meeting and convened the executive session. Following adjournment of the executive session, the meeting was re-convened. There being no further business to come before the Board, the meeting was adjourned.